Midstate Rheumatology Center, P.A.

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	**Marital status (circle one)** Single / Married / Divorced / Separated / Widowed			
Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**	**(Former name):**	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F	
Street address:	**Social Security no.:**	**Home phone no.:** ( )	**Cell phone no.:** ( )			
City:	**State:**	**ZIP Code:**	**Email:**			
Occupation:	**Employer:**	**Employer phone no.:**				
Race: ❑ American Indian or Native Alaskan ❑ Asian ❑ White ❑ Native Hawaiian or Pacific Islander ❑ Black or African American ❑ Hispanic ❑ Other ❑ Prefer not to respond		**Ethnicity:** ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Prefer not to respond				
Language: ❑ English ❑ Spanish ❑ Indian(includes Hindi and Tamil) ❑ Russian ❑ Other						
With whom may we share information about your account?	**Relationship:**	**Phone:**				
Primary Care Physician:	**Address:**	**Phone:**				
Pharmacy:	**Address:**	**Phone:**				
How were you referred to our practice?	❑ Friend/Relative ❑Yellow Pages ❑Newspaper ❑Physician or (if so, who?)_____					

INSURANCE INFORMATION

Person responsible for this account:	**Birth date:** / /	**Address (if different):**	**Home phone no.:** ( )	
Is this person a patient here? ❑ Yes ❑ No				
Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:** ( )	
Name of Primary Insurance (if applicable):				
Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:** / /	**Group no.:**	**Policy no.:**
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other			
Name of secondary insurance (if applicable):	**Subscriber's name:**	**Subscriber's S.S. no.:**	**Birth date:** / /	**Group no.:**
Policy no.:	**Patient's relationship to subscriber:**	❑ Self ❑ Spouse ❑ Child ❑ Other		

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with insurer). It is the responsibility of the patient to know if their insurance requires a referral for the services provided by this practice. The patient will be responsible for payment of denied services in the absence of a required referral.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

The practice reserves the right to assess interest at the rate of one and a half (1.5%) percent per month on all balances that remain unpaid beyond thirty days.

I have received notice of this organization's privacy policies.

_____ _____

Patient/Guardian signature ***Date***